

City of Newport News
Report of Accident, Damage, or Injury



Office of Risk Management, 700 Town Center Drive, Ste. 230, Newport News, VA 23606 Phone: (757) 926-1315

Person/Firm making claim (full name): _____

Address: _____

City & State _____ Zip _____

Primary Contact # _____ E-Mail _____

Social Security No. ____/____/____ DOB _____

Are you a Medicare beneficiary? ____ Yes ____ No Medicare No. _____

(Above information is required before any payment is considered)

Date of Accident/Loss ____/____/____ Time of Accident/Loss _____ __AM __ PM

Exact Location of Accident/Loss Required _____

Description of Accident/Loss (attach photos) _____

Witnesses (if any) (name, address & phone number): _____

Name of City Employee involved: _____

Type of claim being made ____ Auto Damage ____ Injury ____ Property Damage ____ Other

For Auto Damage

Vehicle Owner _____

Make of Auto _____ Model _____ Color _____

Year _____ License Plate & VIN # _____

Do you have insurance? ____ Yes ____ No Carrier: _____ Policy #: _____

Is there a lien on your vehicle? ____ Yes ____ No

If so, lien holder name, address & phone number _____

For Injury

Nature of Injury _____

Were you treated? ☐ Yes ☐ No Did you miss time from work ☐ Yes ☐ No

Name and Address of Doctor/Hospital _____

Are you still under treatment? ☐ Yes ☐ No By whom _____

Current treatment is for _____

Do you have health insurance? ☐ Yes ☐ No

For Property Damage

Description of damage (attach photos) _____

Is this property insured? ☐ Yes ☐ No By whom _____

Name/Address of Property Owner: _____

Any additional information that you feel we should be aware of: _____

The furnishing of this form to you is for your convenience and is not an acknowledgement of liability or waiver of rights by the City of Newport News. Return any written repair estimates or bills with this form.

Omission of facts may cause delay or affect the outcome of the claim, so please complete fully and in detail. Falsification of information on this claim form may result in a denial of your claim.

Signature

Date

Mail Completed Form to:

**City of Newport News
Office of Risk Management
700 Town Center Drive, Suite 230
Newport News, VA 23606**